

## Medical Records Release Form

PATIENT NAME	DATE OF BIRTH
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### Prior Medical Practices

LIST AS MANY PAST/CURRENT MEDICAL OFFICES WE SHOULD CONTACT

PHYSICIAN NAME	CLINIC NAME	PHONE NUMBER
PHYSICIAN NAME	CLINIC NAME	PHONE NUMBER
PHYSICIAN NAME	CLINIC NAME	PHONE NUMBER

### Medical Records to Include:

<b>ALL RECORDS</b> <input type="radio"/>	<b>LAB RESULTS ONLY</b> <input type="radio"/>	<b>RADIOLOGY RECORDS ONLY</b> <input type="radio"/>	<b>MENTAL HEALTH RECORDS</b> <input type="radio"/>
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I HEREBY AUTHORIZE THE CLINICS LISTED ABOVE TO RELEASE MY MEDICAL RECORDS TO:

PENINSULA DOCTOR  
 ATTN: DR. KROES & DR. HIROSHIMA  
 401 BURGESS DR. SUITE A  
 MENLO PARK, CA 94025

P +1 (650) 800-3365  
 F +1 (650) 252-0043 (MAX 15 PAGES)

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 PATIENT SIGNATURE

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 DATE